

OPERATION FOR CURE OF LARGE INCARCERATED HERNIA OF LONG STANDING.

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As several articles have recently appeared in the *ANNALS OF SURGERY* against the advisability of operating in large incarcerated hernias of long standing, I wish to report a case which first came to my notice about one year ago, when I secured the following history.

Woman, married, aged fifty-four. Said that twenty years ago, during the labor of her first confinement, she felt in the region of the umbilicus a violent pain, and noticed thereafter the appearance of a swelling about the size of a walnut. This swelling gradually increased, more rapidly during the last five years, during which period it increased in size one-half. Occasional attacks of localized peritonitis occurred, which at first were mild and infrequent; but as the tumor grew in size these attacks became more frequent and far more severe in character.

On examination, I found a tumor extending from the umbilicus to the knees, measuring twenty-six inches; with patient seated on an ordinary chair it came within six inches of touching the floor. The tumor was distended, soft, and elastic; on percussion in some places it was dull, in others tympanitic; the skin was thin, stretched, glossy, and marked by numerous dilated veins, pressure being quite painful. This tumor was evidently an umbilical hernia, and at first I advised against an operation because of the enormous size of the tumor, the contents of which, I believed, were most of the large and small intestines, with the mesentery and omentum. As the sac of the tumor was made up at the expense of the abdominal wall, I did not see how it

would be possible to secure enough skin and peritoneum to cover the viscera if they could be replaced.

About the first of last November I was hastily summoned to see her. On my arrival, upon examination I found several large ulcers in the wall of the sac, from which a considerable amount of fluid had made its escape. After repeated examination, I finally advised that an operation should be essayed.

She was removed to the hospital, and in a few days I proceeded with the operation. Upon incising the anterior surface of the sac, it was found to contain part of the ascending, the transverse, and part of the descending colon, all of the small intestine with the exception of a small part of the duodenum and ileum, with the mesentery and omentum. The bowels, both large and small, with the omentum, were firmly adhered, the result of the frequent attacks of peritonitis. Many of the adhesions were so firm and well organized that it was necessary to carefully dissect them loose or ligate before separating them from the hernial sac.

The abdominal ring through which the viscera made their exit from the abdomen was about fourteen inches in circumference, and upon placing my hand within the abdomen it seemed that it might be impossible to replace the viscera within its cavity. While there seemed to be enough skin, yet so much of the peritoneum had been taken to form the sac that but little space was left, and not until the last coil of intestine was detached was I certain that the space was sufficiently large to retain them. The last coil of intestine to be detached was the colon, which was firmly grown to the under side of the ring for a space of four inches.

So firmly were the intestines packed within the abdomen that I considered it a matter of grave importance as to whether I should close the ring or not, since this could not be done without increasing the pressure, from which I would expect to meet serious symptoms; and, on the other hand, should I not close it, I feared a return of the hernia. I decided finally to use a part of the sac for a covering to close the ring, and finished the operation by approximating the edges of the skin.

It required two hours to perform the operation, and naturally there was some shock. After the patient was placed in bed her pulse registered 120 beats to the minute, though in the

evening it dropped to 96, only to increase again the following morning to 108, from which time there was a gradual increase until the ending of the third day, when it was 133. It then declined again, and during the next four days it ranged between 112 and 120.

The temperature on the first day ranged from 98° to 98.5° F., after which it registered from 99.5° to 100.2°. The highest point was reached on the morning of the ninth day, after which it gradually receded to normal, though the pulse continued above 100 for two weeks.

The most serious symptom was that of vomiting, the rejected matter being of a dark brown color. This was so persistent that we were unable to take her temperature by mouth during the first week. Everything in the way of nourishment was vomited for the first four days, and only through repeated efforts were we able to have her retain cathartics enough to be effective. We did not succeed in moving her bowels until the fourth day. Some of these symptoms may have been of septic origin, since, as stated before, it was a pus case to start with. Also, owing to the large size of the tumor, it was impossible to thoroughly asepticize it; further than this, a coil of bowel was adhered to the sac just over the point of perforation, and at this place the bowel was diseased. With these conditions one would naturally be on the alert for danger signals.

I attributed, however, the persistent vomiting, as well as some of the other conditions, to pressure of the viscera against the stomach. After abdominal operations a common complaint is of gas in that region, and, since there was no room for distention in any other direction, there would necessarily be considerable force exerted in that direction, causing vomiting and a rapid pulse.

The patient returned to her home in less than four weeks, and her recovery is complete.